Supreme Court, U.S.
FILED
NOV 30 2009
OFFICE OF THE CLERK

No. 09-364

IN THE

Supreme Court of the United States

DRALVES GENE EDWARDS,

Petitioner,

v.

BLUE CROSS BLUE SHIELD OF TEXAS,
A DIVISION OF HEALTH CARE SERVICE CORPORATION,
A MUTUAL LEGAL RESERVE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
COURT OF APPEALS OF TEXAS, FIFTH DISTRICT

BRIEF IN OPPOSITION

JOHN B. SCOTT
Counsel of Record
ANDREW W. YUNG
DENNIS J. KEITHLY
SCOTT YUNG LLP
208 N. Market Street, Suite 200
Dallas, Texas 75202
Phone: (214) 220-0422
Facsimile: (214) 220-9932

Attorneys for Respondent

226670

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

QUESTION PRESENTED

Respondent objects to the format of the "Question Presented" by the Petitioner. The question was presented by Petitioner as:

> Whether the Texas Court of Appeals wrongly concluded (contrary to the decisions from other federal and state courts of appeals) that all state law claims for consequential damages against Medicare fiscal intermediaries are preempted under the Medicare Act.

The Texas Court of Appeals did not conclude that all state law claims for consequential damages against a Medicare fiscal intermediary are preempted under the Medicare Act. Pet'r's. App. 20. The Texas Court of Appeals specifically distinguished cases where state law claims were permitted to proceed against Medicare fiscal intermediaries for wrongful death or damages for state law torts for delays in granting the benefits. *Id.* As discussed in the body of this brief, the Texas Court of Appeals held that the claims brought by the Petitioner, as a Medicare provider seeking consequential damages for denial of benefits, were preempted as a matter of law. *Id.* at 22.

Respondent would respectfully submit to the Court that the proper question presented is:

> Whether the Texas Court of Appeals properly concluded (in accordance with decisions from other federal and state courts of appeals) that Petitioner's state laws claims for alleged consequential damages against a Medicare fiscal intermediary are preempted under the Medicare Act.

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

TABLE OF CONTENTS ii

TABLE OF CITED AUTHORITIES v

BACKGROUND AND INTRODUCTION 1

MISSTATEMENTS AND INACCURACIES IN THE PETITION 2

A. Petitioner has Inaccurately Described the Nature of the Prepayment Review. 2

B. Petitioner Attempts to Characterize his Medicare Claims as Claims for Breach of Contract. 3

C. Petitioner's Description of the Procedural History of this Case is Inaccurate and Misleading. 3

D. If Taken as True, Petitioner's Concession that He has Concluded the Administrative Appeals Process Renders any Further Review Moot. 4

Contents

	Page
ARGUMENT AND AUTHORITIES	5
I. THE COURT OF APPEALS HOLDING THAT PETITIONER'S CLAIMS WERE INEXTRICABLY INTERTWINED WITH CLAIMS FOR MEDICARE BENEFITS SHOULD BE AFFIRMED.	5
A. Petitioner Brought His Claims for Damages in the Wrong Court and Against the Wrong Defendant.	5
1. The Relevant Medicare Statutory Background.	6
2. The Role of the Medicare Contractor.	7
3. Administrative and Judicial Review of Benefit Determinations.	8
B. Petitioner's Claims Arise Under the Medicare Act.	11
1. Conduct Alleged by Petitioner Giving Rise to His Claims.	11

Contents

Page

2. Contrary to Petitioner's Assertions, there is No Split Amongst the Circuits Concerning the Review of Medicare Benefit Determinations. 16

3. The Administrative Appeals Process is Petitioner's Sole Remedy. 19

II. PETITIONER ASKS THE COURT TO CREATE A NEW TOLLING THEORY UNSUPPORTED BY ANY LAW. 21

CONCLUSION AND PRAYER 24

TABLE OF CITED AUTHORITIES

Page

FEDERAL COURT CASES

Affiliated Prof'l Home Health Care Agency v. Shalala,
164 F.3d 282 (5th Cir. 1999) 10, 12, 14

Ardary v. Aetna Health Plans of Southern Cal.,
98 F.3d 496 (9th Cir. 1996) 16, 17, 18

Bodimetric Health Servs.,
903 F.2d 480 (7th Cir. 1990) ..... *passim*

Heckler v. Ringer,
466 U.S. 602 (1984) 5, 8-9

Hofler v. Aetna U.S. Healthcare of Cal., Inc.,
296 F.3d 764 (9th Cir. 2002) 16-17

Hooker v. U.S. Dep't of Health and Human Servs.,
858 F.2d 525 (9th Cir. 1988) 20

Kaiser v. Blue Cross of Cal.,
347 F.3d 1107 (9th Cir. 2003) 13, 15, 17, 18

Kelly v. Advantage Health, Inc.,
1999 WL 294796 (E.D. La. 1999) 18

Kennedy v. Health Options, Inc.,
329 F. Supp. 2d 1314 (S.D. Fla. 2004) 17

Cited Authorities

Page

Marin v. HEW, Health Care Fin. Agency,
769 F.2d 590 (9th Cir.1985) 13

Marsaw v. Blue Cross-Blue Shield of Tex. Health Enters., L.L.C.,
192 F.Supp.2d 737 (S.D. Tex. 2002) 13, 19

Marsaw v. Thompson,
133 Fed Appx. 946, 2005 WL 1170445
(5th Cir. 2005) 19, 20

Midland Psychiatric Assocs. v. United States,
145 F.3d 1000 (8th Cir. 1998) 13, 15

Plocica v. Nylcare, Inc.,
43 F. Supp. 2d 658 (N.D. Tex. 1999) 17

Schweiker v. Chilicky,
487 U.S. 412 (1988) 20

Shalala v. Ill. Council on Long Term Care, Inc.,
529 U.S. 1 (2000) 5, 8, 11

United States v. Blue Cross & Blue Shield of Ala., Inc.,
156 F.3d 1098 (11th Cir.1998) 14

Wartenberg v. Aetna U.S. Healthcare, Inc.,
2 F. Supp. 2d 273 (E.D.N.Y. 1998) 17

Weinberger v. Salfi,
422 U.S. 749 (1975) 10

Cited Authorities

Page

FEDERAL STATUTES

42 U.S.C. § 405(g) ..... *passim*

42 U.S.C. § 405(h) ..... *passim*

42 U.S.C. § 1395d 6

42 U.S.C. § 1395f 7

42 U.S.C. § 1395g(a) 7

42 U.S.C. § 1395k(a) 6

42 U.S.C. § 1395u(b)(3) 7

42 U.S.C. § 1395y(a) 7

42 U.S.C. § 1395cc(a) 7

42 U.S.C. § 1395ff 5

42 U.S.C. § 1395ii 5

REGULATIONS

20 C.F.R. § 404.981 9

20 C.F.R. § 422.210(a) 9

20 C.F.R. § 422.210(c) 9

Cited Authorities

	Page
20 C.F.R. § 422.210(d)	9
20 C.F.R. § 481	9
42 C.F.R. § 405.501	7
42 C.F.R. § 405.803	8
42 C.F.R. § 405.807	8
42 C.F.R. § 405.815	8
42 C.F.R. § 405.821	8
42 C.F.R. § 405.855	8
42 C.F.R. § 405.856	8
42 C.F.R. § 405.857	9
42 C.F.R. § 410.20	6
42 C.F.R. § 410.60	6
42 C.F.R. § 410.200	7
42 C.F.R. § 421	7
42 C.F.R. § 421.5	7
42 C.F.R. § 421.200(a)	7
42 C.F.R. § 421.200(e)	7

BACKGROUND AND INTRODUCTION

Petitioner is a Texas physician who chose to treat patients covered by Medicare. By doing so, he was required to comply with the rules and regulations of Medicare. Not satisfied with the recovery he alleges to have received from Medicare, he set forth to get a little extra for his efforts from the Respondent, a fiscal intermediary for the Medicare system. Petitioner now finds his case entangled in a web of deceit of his own making. The Petition for Writ is full of misrepresentations and misstatements of fact and law. His Writ tries to ensnare this court in his web to overcome the prior decisions of the trial court, the court of appeals, and the Texas Supreme Court.

The underlying factual basis of the Petitioner's lawsuit was the handling of Medicare claims. When faced with the exclusive remedy provided by Medicare to a physician who appeals the denial of a claim, he added state law claims and tried to distance his case from his new remedies. Petitioner was then faced with a limitations bar and so he created a new theory of law: that his state law claims were tolled while appealing his Medicare claims. This reliance on Medicare to provide a lifeline to his dead claims created the intertwined allegations which have been presented to the Court.

The Petitioner's Writ stands as an excellent example of his state law claims being inextricably intertwined with his Medicare claims. Ultimately, all of his state law complaints require an evaluation of some underlying Medicare claim to determine any basis for the claim. Inherent in such an analysis is a determination of what

should have been done with the Medicare claim. Once down this path, it is impossible not to have courts improperly rendering opinions on how Medicare claims should be handled. As described below, the current system is specifically designed to avoid such confusion.

MISSTATEMENTS AND INACCURACIES IN THE PETITION

Pursuant to Rule 15(2) of the Rules of the Supreme Court of the United States, Respondent would respectfully submit to this court that Petitioner has made a number of factual and legal misstatements in his Petition. Respondent hereby addresses these issues as they bear on what issues would properly be before the Court if certiorari were to be granted.

A. Petitioner has Inaccurately Described the Nature of the Prepayment Review.

On page six of his Petition, Petitioner states that "[a]lthough medical necessities are covered under Medicare, Blue Cross categorically denied medical conditions such as breast cancer, congestive heart failure, and diabetes." Petitioner's statement is misleading as Respondent did not deny or place any "medical conditions" under prepayment review. Instead, the services provided by Petitioner were placed under a prepayment review to determine the medical necessity of the treatment. Similarly, Petitioner notes on page seven of his Petition that "two independent board certified Internal Medicare Specialists reviewed Dr. Edwards' claims and concluded that all medical

conditions were covered under Medicare and should have been paid." Again, Petitioner confuses the purpose and scope of the prepayment review. A medical condition itself is not the issue. The prepayment review of claims by the Petitioner to Medicare was, on all of the claims he seeks, the real issue.

B. Petitioner Attempts to Characterize his Medicare Claims as Claims for Breach of Contract.

Petitioner attempts to recast the nature of his Medicare claims on page nine of his Petition. Petitioner states that "Edwards' complaint did not, however, request damages for an illegal denial of Medicare payments, it raised only state law breach of contract claims." The problem remains that in more than a decade of litigation, he has failed to identify any damage for breach of contract that is not an alleged failure to pay a Medicare claim. The basis of all of Petitioner's claims was his allegation that Respondent improperly denied his claims for Medicare benefits.

C. Petitioner's Description of the Procedural History of this Case is Inaccurate and Misleading.

In a further attempt to disguise the nature of his claims, Petitioner misrepresents the procedural history of this dispute at the trial court level. On page nine of his Petition, Petitioner states "the case filed against Blue Cross and Blue Shield of Texas – and not the Government, its employees or officers – was removed to federal court in 2005. The federal court remanded

the case, finding lack of diversity or federal question jurisdiction." This statement is too simple a statement of the procedural history of this matter and is misleading. After bringing suit against Respondent, Petitioner subsequently added Trailblazer, another insurance company, as a defendant. Trailblazer then removed the case to federal court. Petitioner then dismissed his claims against Trailblazer. During the removal by Trailblazer, Respondent did not make a showing of an exclusive federal issue. Therefore, the district court then remanded the case to state court but noted that Respondent could still raise its federal defenses, which it has throughout the course of this litigation.

D. If Taken as True, Petitioner's Concession that He has Concluded the Administrative Appeals Process Renders any Further Review Moot.

Petitioner concedes that he has received the very benefits he alleges were denied to him by Respondent. On page eighteen, in discussing the review process, Petitioner notes that "the review the court of appeals decried was already conducted successfully through the administrative review process." In addition, on page nineteen of his Petition, he notes that "Edwards has already received benefits through the exhaustive administrative appeals." As discussed below, these statements, if taken as true, foreclose any further consideration of any of the Medicare claims that form the basis of Petitioner's lawsuit.

ARGUMENT AND AUTHORITIES

I. THE COURT OF APPEALS HOLDING THAT PETITIONER'S CLAIMS WERE INEXTRICABLY INTERTWINED WITH CLAIMS FOR MEDICARE BENEFITS SHOULD BE AFFIRMED.

A. Petitioner Brought His Claims for Damages in the Wrong Court and Against the Wrong Defendant.

Petitioner's lawsuit for the alleged tort claims is in direct contradiction to the exclusive nature of Medicare Act's judicial review provisions. It is well-settled that, "[t]he third sentence of 42 U.S.C. § 405(h), made applicable to the Medicare Act by 42 U.S.C. § 1395ii, provides that § 405(g) . . . is the sole avenue for judicial review for all 'claim[s] arising under' the Medicare Act." *See Shalala v. Ill. Council on Long Term Care, Inc.* 529 U.S. 1, 35 (2000), quoting, *Heckler*, 466 U.S. 602, 614-615 (1984). As discussed below, Petitioner's lawsuit sought the wrong relief, against the wrong party, in the wrong court.[1]

[1] If Petitioner was dissatisfied with the final decision of the Secretary of Health and Human Services, he should have filed an action against the Secretary in federal district court seeking reversal of the denied claims, as expressly set forth in 42 U.S.C. §§ 405(g), (h). If Petitioner was seeking remedies not set forth in that limited judicial review, then Petitioner's remedies and claims are preempted by the Supremacy clause and the very terms of the statute itself.

1. *The Relevant Medicare Statutory Background.*

The Medicare program, established by Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq.*, assists elderly and disabled persons in the purchase of necessary health care. The Centers for Medicare and Medicaid Services ("CMS") is the component of the United States Department of Health and Human Services ("DHHS") which administers the Medicare program. The program is divided into two primary parts: one program is called "Hospital Insurance Benefits for the Aged and Disabled" (or Medicare Part A) and the other program is the "Supplementary Medical Insurance Benefits for the Aged and Disabled" (or Medicare Part B). Medicare Part A pays for inpatient hospital stays, skilled nursing care, hospice and certain home health services.[2] Medicare Part B provides for outpatient physical therapy, occupational therapy, speech pathology, doctors' services, diagnostic tests, ambulatory services, durable medical equipment, mental health services, clinical laboratory services, limited home health care, outpatient hospital services and blood provided on an outpatient basis.[3] At issue in this case are Medicare Part B benefits which include payment for doctors' services.[4]

---

[2] *See* 42 U.S.C. §1395d.

[3] 42 U.S.C. §1395k(a); 42 C.F.R. § 410.60.

[4] 42 C.F.R. § 410.20.

2. *The Role of the Medicare Contractor.*

The Secretary is authorized to contract with private insurance companies to handle the administrative details of Part B reimbursements.[5] Medicare carrier contracts are not conventional Government contracts. The carrier is not permitted to earn profit on the contract, and the carrier's costs are passed directly to the Government. The carrier is bound by the Medicare statute, the regulations, and the guidelines issued by CMS. Under the Medicare statute, a contractor may make payments only to a holder of a valid Medicare provider agreement.[6] Medicare providers' claims for payment are sent to the carrier for processing and payment.[7] The carrier reviews the claim and pays benefits according to detailed, pre-established procedures set out in the Medicare Act.[8] The carrier must ensure that payment is made only for services that are furnished to Medicare beneficiaries and covered under the Medicare program, and must deny payment for services which are not reasonable or medically necessary.[9] Payments to the provider are made out of the Medicare Trust Fund; the carrier has no vested interest in the Medicare fund. The carrier is also required to conduct audits of the records of providers, as necessary, to assure that payments are made properly.[10]

---

[5] 42 C.F.R. § 421.5; *See generally,* 42 C.F.R. § 421.200, *et seq.*

[6] *See* 42 U.S.C. §§ 1395f, 1395g(a), and 1395cc(a).

[7] *See* 42 C.F.R. Part 421.

[8] 42 U.S.C. §§ 1395u(b)(3), 1395y(a), the CMS regulations, see 42 C.F.R. §§ 405.501 *et seq.*, 421.200, and other instructions issued by CMS.

[9] 42 C.F.R. §421.200(a).

[10] 42 C.F.R. §421.200(e).

3. *Administrative and Judicial Review of Benefit Determinations.*

Congress has provided for an elaborate and exclusive review process to be used by parties dissatisfied with the initial disposition of their Medicare claims.[11] The Medicare carrier makes an initial determination when a request for payment for Part B benefits is submitted and may also review determinations after payment has been made.[12] If a provider of medical services is dissatisfied with the initial determination, it may request a review of the claim.[13] Following the carrier's review determination, the provider may obtain a carrier hearing if the amount remaining in controversy is at least $100.[14] If the provider is dissatisfied with the hearing officer's decision, it may request a hearing before an administrative law judge ("ALJ").[15] If a provider is dissatisfied with the ALJ's decision or with the dismissal of a hearing request, it may request that the Departmental Appeals Board, Medicare Appeals Council, review that action.[16] The Medicare Appeals Council may deny or dismiss the request for review, or it may grant the request and either issue a decision or

---

[11] 42 U.S.C. §§ 405 (g) & (h), 1395ff.

[12] 42 C.F.R. §405.803; 42 U.S.C. §1395ff.

[13] 42 C.F.R. §405.807

[14] 42 C.F.R. §§405.815 and 405.821

[15] 42 C.F.R. §§405.815 and 405.855.

[16] 42 C.F.R. §405.856 (The Medicare Appeals Council ("MAC")is part of the Departmental Appeal Board of DHHS)

remand the case to an ALJ.[17] Administrative exhaustion is attained when the provider seeks and receives a determination from the Medicare Appeals Council.[18] Thus, a provider may obtain judicial review of a decision by an ALJ if the Medicare Appeals Council has denied the provider's request for review, or if the Medicare Appeals Council issues the final decision of the Secretary.[19] Any civil action for judicial review must be instituted within 60 days after the Medicare Appeals Council's notice of denial of request for review of the ALJ's decision or notice of the decision by the Medicare Appeals Council is received.[20] Where any civil action for judicial review is instituted, the Secretary of the Department of Health and Human Services, in his or her official capacity, is the only proper defendant.[21]

A well-recognized line of United States Supreme Court cases establish that jurisdiction under the Medicare Act to review decisions of the Secretary is limited to that provided for in 42 U.S.C. § 405(g) by the language of § 405(h). These cases establish that Medicare reimbursement disputes must be addressed solely in accordance with the dictates of 42 U.S.C. § 405(g). *See Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 120 S.Ct. 1084, 146 L.Ed.2d 1 (2000); *Heckler v. Ringer*, 466 U.S. 602, 605, 104 S.Ct. 2013, 80 L.Ed.2d

---

[17] 20 C.F.R. §481.

[18] 42 C.F.R. § 405.857; 20 C.F.R. § 422.210(a).

[19] 42 C.F.R. § 405.857.

[20] 20 C.F.R. § 404.981; 20 C.F.R. § 422.210(c)

[21] 42 U.S.C. § 405(g); 20 C.F.R. § 422.210(d).

622 (1984); *Weinberger v. Salfi*, 422 U.S. 749, 760-61 (1975); *Affiliated Professional Home Health Care Agency v. Shalala*, 164 F.3d 282 (5th Cir. 1999).

The plain language of § 405(h), as incorporated by 42 U.S.C. § 1395ii, expressly limits the review of claims that "arise under" the Medicare Act:

> The findings and decision of the Secretary after such a hearing shall be binding upon all individuals who were parties to such a hearing. *No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided.* No action against the United States, the Secretary, or any officer or employee shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

(emphasis added).

The Medicare Act simply does not allow judicial review of the Secretary's decisions by the state courts. 42 U.S.C. § 405(g) states, in relevant part:

> Any individual, after any final decision of the [Secretary] made after a hearing to which he was a party, . . . may obtain a review of such decision by a civil action. . . . Such action *shall be brought in the district court of the United States*. . . . The court shall have power to enter . . . a judgment affirming, modifying, or reversing the decision of the [Secretary]....

> The findings of the [Secretary] as to any fact, if supported by substantial evidence, shall be conclusive. . . .

(emphasis added).

Thus, any claim "arising under" the Medicare Act must be brought through the exclusive judicial review provision of the Medicare Act, 42 U.S.C. § 405(g), regardless of whether it is denominated as procedural or constitutional. *See Ill. Council*, 120 S.Ct. at 1094. The statute does not provide for review in state court jury trials.

B. Petitioner's Claims Arise Under the Medicare Act.

The Dallas Court of Appeals correctly held that Petitioner's claims against Blue Cross Blue Shield of Texas were properly dismissed since jurisdiction to review claims "arising under" the Medicare Act against carriers acting on behalf of the Secretary, is limited to that allowed by 42 U.S.C. §§ 405(g) and (h). At bottom, Petitioner was claiming that Medicare should have paid for his services.

1. *Conduct Alleged by Petitioner Giving Rise to His Claims.*

Dr. Edward's claims are predicated on the determination of Medicare benefits. As a result of Respondent's denial of Medicare claims payment, Petitioner alleged that "Defendants owe money to Dr. Edwards for services rendered to his patients" and

sought damages for breach of contract, fraud, gross negligence, tortious interference with Petitioner's relationship with his patients and with his prospective relationship with future patients, abuse of process, libel, slander, unjust enrichment and damages under the Texas Medical Liability Act.

It was clear to the court of appeals that the basis of Petitioner's dispute with Respondent was the review and denial of Medicare benefits and attempts to recover special damages. Petitioner's state court claims clearly "arose under" the Medicare Act. Petitioner alleges that Respondent denied almost one-hundred percent (100%) of all Medicare claims submitted for payment stating that the claims were for non-covered services and/or were not medically necessary. Pet'r's. Br. p. 8. The court of appeals correctly concluded that "the trial court would have to review each of Edwards's Medicare reimbursement claims and Blue Cross's decision to deny them in order to determine if there was a good faith or non-tortious basis for Blue Cross's actions." Pet'r's. App. 17. Therefore, the court of appeals concluded that Edwards's claims "[arose] under the Medicare Act (and are not collateral to it) because they are 'inextricably intertwined' with [Petitioner's] substantive claims for entitlement under Medicare." Pet'r's. App. 18.

Furthermore, every cause of action expressly or implicitly raised by Petitioner's Petition has been found by other courts in other cases to "arise under" the Medicare Act:

- *Affiliated Professional Home Health Care Agency v. Shalala*, 164 F.3d 282, 285 (5th Cir. 1999)(due process and equal protection);

- *Bodimetric Health Servs. v. Aetna Life & Cas.*, 903 F.2d 480 (7th Cir. 1990); *Midland Psychiatric Associates v. United States*, 145 F.3d 1000, 1003 (8th Cir. 1998)(state law tort claims);

- *Kaiser v. Blue Cross of Cal.*, 347 F.3d 1107 (9th Cir. 2003)(contractual claims, constitutional claims, defamation, other business torts);

- *See Marin v. HEW, Health Care Fin. Agency*, 769 F.2d 590, 592 (9th Cir.1985) (noting, in a home health service provider's suit against the government "for damages caused by negligent failure to process" claims, that "[t]he substantive cause of action [was] anticipated by the statute" and that the plaintiff's "demand for greater damages than the statute provides would render meaningless the jurisdiction restriction of § 405(h)"); and

- *Marsaw v. Blue Cross-Blue Shield of Tex. Health Enters., L.L.C.*, 192 F. Supp. 2d 737, 744 (S.D. Tex. 2002) (contractual claims, constitutional claims, business torts).

Moreover, courts, both state and federal, have considered numerous cases that do not, on their face, appear to claim specific Medicare benefits or reimbursements yet have been found to arise under the Medicare Act. One category of such cases are those cases

that are "[c]leverly concealed claims for benefits." *United States v. Blue Cross & Blue Shield of Ala., Inc.*, 156 F.3d 1098, 1109 (11th Cir.1998).

In the *Affiliated Professional* ("APRO") case, the Fifth Circuit explained that:

> . . . to fully address [a provider's] claim that their due process and equal protection rights were violated through the improper enforcement of Medicare regulations, a court would necessarily have to immerse itself in those regulations and make a factual determination as to whether [the provider] was actually in compliance. Given the administrative nature of that inquiry, it cannot be reasonably concluded that [the provider's] claim is collateral to a claim for administrative entitlement.

164 F.3d at 285. Likewise, a trial court in the instant case reviewing Petitioner's claims would necessarily have to immerse itself in Medicare regulations and make a factual determination as to whether Petitioner's claims for payment were payable under the Medicare program. This judicial review is reserved to the federal district courts by the express language of 42 U.S.C. §405(g).

In *Bodimetric*, a provider sued the Medicare contractor for damages, fraud, negligent misrepresentation, breach of contract, tortious breach of implied covenant of good faith and fair dealing, and other tort claims. However, the court noted that the

claim was that they should be paid for their services. *Id.* at 484. The *Bodimetric* court held:

> A party cannot avoid the Medicare Act's jurisdictional bar simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits. If litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharacterizing their claims under state and federal causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined.

Bodimetric, 903 F.2d at 487 (citations omitted). The court found that the plaintiff's claims against the Medicare contractor arose under the Medicare Act and that the plaintiff could not circumvent the terms of section 405(h) simply because a private entity serves a public function. *Id.* at 488. "A claim may arise under the Medicare Act even though, as pleaded, it also arises under some other law." *Midland*, 145 F.3d at 1004. "A claim does arise under the Medicare Act if it is 'inextricably intertwined' with a Medicare benefits determination." *Id.*

In *Kaiser v. Blue Cross of Cal.*, 347 F.3d 1107 (9th Cir. 2003), the owners and operators of a Medicare provider sued the Medicare fiscal intermediary alleging violation of the Fifth Amendment, defamation, invasion of privacy, and breach of contract. The court held that the fact that the plaintiffs sought damages beyond reimbursement payments available under Medicare to

the provider did not exclude the possibility that suit arose under the Medicare Act so as to require exhaustion of administrative remedies prior to judicial review pursuant to 42 U.S.C. §405(g) and (h). Similarly, Petitioner's claims are inextricably intertwined with a Medicare benefits determinations and, as such, "arise under" the Medicare Act.

2. *Contrary to Petitioner's Assertions, there is No Split Amongst the Circuits Concerning the Review of Medicare Benefit Determinations.*

Petitioner relies on a series of cases which he claims stand for the proposition that "courts have held that state law claims against a Medicare carrier or fiscal intermediary, such as Blue Cross, are not pre-empted by the Medicare Act." Pet'r's. Br. p. 14. Petitioner improperly relies on these cases in order to create the appearance of a split amongst the circuits concerning the exclusive provisions of the Medicare Act. However, the circuits themselves have eliminated any perceived split.

The cases cited by Petitioner are the progeny of the Ninth Circuit Court of Appeal's decision in *Ardary v. Aetna Health Plans of Southern Cal.*, 98 F.3d 496 (9th Cir. 1996). In those decisions, the courts determined that wrongful death and other state law claims stemming from the failure to provide medical services (not the failure to pay claims) were not inextricably intertwined with a claim for Medicare benefits, and therefore, they did not arise under the Medicare Act. *See, e.g., Hofler v. Aetna US Healthcare of Cal., Inc.*, 296 F.3d 764, 769-

70 (9th Cir. 2002); *also see Kennedy v. Health Options, Inc.*, 329 F. Supp. 2d 1314, 1315-17 (S.D. Fla. 2004); *Plocica v. Nylcare of Tex., Inc.*, 43 F. Supp. 2d 658, 660-663 (N.D. Tex. 1999); *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F. Supp. 2d 273, 277-78 (E.D.N.Y. 1998).

The Ninth Circuit Court of Appeals explicitly limited its own holding in *Ardary* in a subsequent decision. The Ninth Circuit was considering a case where the plaintiff was a health care provider that allegedly was forced into bankruptcy after a Medicare fiscal intermediary began recouping overpayments from Medicare reimbursement checks. *Kaiser v. Blue Cross of Cal.*, 347 F.3d 1107, 1109-10 (9th Cir. 2003). The court stated, "Simply put, the type or remedy sought is not strongly probative of whether a claim falls under § 405(h)." *Id.* at 1112. The court stated that: "[i]ndeed, the *Ardary* analysis convinces us that its holding does not extend beyond patients and torts committed in the sale and provision of medical services." *Id.* at 1113 (emphasis added). Furthermore, the Ninth Circuit found that *Bodimetric* was applicable to the facts of the case, and that the plaintiff's claims for damages was "inextricably intertwined" with a claims for Medicare reimbursement that would require redeciding Medicare decisions, and therefore, the administrative appeals process was applicable. *Id.* at 1114.

Petitioner also attempts to support his claim of a circuit split by erroneously relying on a decision from the Eastern District of Louisiana in support of his claim that his state law tort claims do not arise under the Medicare Act (*i.e.*, are not inextricably intertwined with

a claim for benefits). Pet'r's. Br. p. 15-16. In *Kelly v. Advantage Health, Inc.*, 1999 WL 294796 (E.D. La. 1999) (not designated for publication), the district court considered the plaintiff's motion to remand their suit alleging state law claims against a Medicare provider. *Id.* at *1. Citing *Ardary*, the court determined that an award of benefits would not cure the plaintiff's injuries, which resulted from a delay in providing medical services and not from the denial of benefits. *Id.* at *2. The court distinguished *Bodimetric* and determined there was no underlying claim for benefits. *Id.*

As the court of appeals recognized, the present dispute is clearly distinguishable from *Ardary* and *Kelly*. In this case, Petitioner *is not a patient* seeking damages for the *denial of medical services*. Petitioner did not bring suit against BCBSTX for wrongful death or damages for state law torts for delays in granting medical benefits. Pet'r's. App. p. 20. Petitioner is seeking damages related to the denial of benefits for medical services rendered to patients. As *Bodimetric* and *Kaiser* have shown, Petitioner's causes of action are based on a claim for benefits. Therefore, these claims are inextricably intertwined with a claim for Medicare reimbursement and limited to the remedies available through the administrative appeals process. *Bodimetric* and *Kaiser* are on point, while *Ardary* and its progeny are inapplicable.

Simply put, there is no circuit split. Petitioner's claim of a circuit split is a self-serving attempt to revive his preempted claims and ignores clear precedent. The alleged split described by Petitioner is merely a fiction, and an opinion from this Court will not serve to resolve any dispute amongst the circuits as there is nothing to resolve.

3. *The Administrative Appeals Process is Petitioner's Sole Remedy.*

Congress devised an elaborate and exclusive remedial scheme for providers, such as Petitioner, dissatisfied with the initial payment determination by the carrier. *See* 42 U.S.C. §§ 405(g) and (h). Specifically, a dissatisfied provider, such as Petitioner, may avail himself of the administrative process, at the end of which, either the carrier pays the provider or the provider may seek judicial review of the resulting final agency decision. If the district court ultimately rules in the provider's favor, the remedy is simply payment for claims submitted. Even though a provider may never be able to pursue a state law contract or tort claim if he is successful on administrative appeal, this result is implicit in Congress' scheme and cannot be classified as mere happenstance. *Marsaw v. Blue Cross-Blue Shield of Tex. Health Enters., L.L.C.*, 192 F. Supp. 2d 737, 748 (S.D. Tex. 2002); *Marsaw v Thompson*, 133 Fed Appx. 946, 2005 WL 1170445 (5th Cir. 2005) (not designated for publication) ("Congress created a comprehensive statutory administrative review mechanism, which was intended fully to address the problems created by wrongful denial of Medicare reimbursements.").

In *Bodimetric*, the Seventh Circuit reasoned that:

> By enacting the exclusive review provisions of the Medicare Act, Congress expressly limited the remedies that can be sought by dissatisfied claimants from fiscal intermediaries. While this may, in some cases, foreclose avenues of relief generally available

> to civil litigants, it is also the system Congress clearly intended to implement. Any decision to modify this aspect of the system must be made by Congress, not by the courts.

Bodimetric, 903 F.3d at 490.

Moreover, this Court has made clear that the Medicare Act makes no provision for remedies in money damages against officials responsible for unconstitutional conduct that leads to the wrongful denial of benefits. *Schweiker v. Chilicky*, 487 U.S. 412, 424, 108 S.Ct. 2460, 101 L.Ed.2d 370 (1988). The circuit courts have reasoned that "the demand for damages greater than the Medicare statute provides, renders meaningless the jurisdictional restriction of § 405(h)." *Hooker v. U.S. Dept. of Health and Human Servs.*, 858 F.2d 525 (9th Cir. 1988). Accordingly, the state court was precluded from reviewing the propriety of the Medicare denials issued by the Secretary.

Finally, even in cases where the Secretary has reversed the initial claims denials issued by Respondent, a provider is not entitled to any additional damages based on the Medicare contractor's initial denial. *Marsaw*, 133 Fed. Appx. 946, 2005 WL 1170445 (not designated for publication) ("Because Marsaw has now received precisely the Medicare payments he claims were wrongfully denied, and the statute entitles him to no other relief, his case is moot."). Congress established the Medicare appeals process to give providers an opportunity to receive review of erroneously denied

Medicare claims, not to build a case against a Medicare contractor.[22]

Although Petitioner characterizes his complaint as a claim for damages, Plaintiff's complaint is simply a dispute concerning the denial of Medicare claims and alleged supplemental/consequential damages from such denial. Furthermore, Petitioner's concession that he was successful on the administrative review of his claims forecloses any further review and renders his Petition moot.

II. PETITIONER ASKS THE COURT TO CREATE A NEW TOLLING THEORY UNSUPPORTED BY ANY LAW.

Despite Petitioner's firm conviction that his claims are not inextricably intertwined with a claim for Medicare benefits, Petitioner insists that he was required to exhaust the administrative appeals process. Despite a lack of any probative evidence that Petitioner actually completed the appeals process, Petitioner alleges that he was required to engage the review process, and that his alleged participation in this process tolled the limitations on his state law claims. Petitioner's

---

[22] Petitioner would use the administrative review process to dispense with any proof that Respondent acted with any malice while denying claims. Petitioner's theory is that no review of his Medicare bills is needed as he had allegedly won "the majority" of administrative reviews. Pet. Br. pp. 10, 18, 19. However, Petitioner does not, and indeed cannot, show how many reviews were successful or that the MAC or any other entity found that Respondent improperly denied, much less denied with malice, any of Petitioner's Medicare claims.

presentation of his claims for judicial review suffers from two defects: 1) as previously discussed, his state law tort claims were inextricably intertwined with a claim for Medicare benefits; and 2) if his state law tort claims were not inextricably intertwined, then they were barred by limitations. In the present dispute, it is impossible for Petitioner to resolve one defect without invoking the other.

In order to overcome this quandary, Petitioner has asked every court that has heard this matter to adopt his novel and unsupported limitations theory. In order to understand this theory, Petitioner's allegations warrant a brief review. Petitioner's allegations seeking liability against BCBSTX in this lawsuit appear essentially to be as follows:

> (1) that Respondent had a scheme that was detectable in 1997, and confirmed in 1998, to inappropriately deny the vast majority of Petitioner's Medicare claims assigned by Medicare enrollees who received the services from Petitioner;
>
> (2) that the foreseeable consequence of denying these Medicare claims was Petitioner's consequential damages (loss of profits, mental anguish, and the like); and
>
> (3) although these consequential damages and related state law claims are not inextricably intertwined with seeking payment for any Medicare claims, for some reason the statute of limitations was tolled

> until all of the Medicare claims had been appealed to their fullest through the administrative process and the federal statute.

Petitioner asks this Court, and every other Court that has heard this dispute, to declare that his claims were not inextricably intertwined with a claim for Medicare benefits, thereby paving the way for Petitioner to recover damages in the wrong court against the wrong defendant, but at the same time his claims were somehow subject to the administrative review process which tolled the statute of limitations and prevented his claims from becoming barred as a matter of law. Neither the law nor logic supports this alarming attempt to avoid Texas limitations law and the Medicare jurisdictional scheme.

Petitioner has inappropriately asked all the courts involved in this matter to make new law on Texas tolling while disregarding settled federal law related to Medicare jurisdiction for physicians and hospital claims. The law is straightforward – Petitioner brought his suit in the wrong court and against the wrong defendant and Petitioner's claims were properly dismissed by the trial court for lack of jurisdiction and preemption. The dismissal was affirmed on the basis of preemption by the court of appeals. If as Petitioner claims, however, these are plain-vanilla state law claims against Respondent, then no limitations tolling should be recognized and Petitioner's state law claims expired prior to this lawsuit being filed in 2003.

CONCLUSION AND PRAYER

Petitioner has failed to demonstrate that there is any split amongst the circuit courts of appeal concerning whether a claim by a Medicare provider for consequential damages that allegedly resulted from the denial of Medicare benefits is inextricably intertwined with a claim for Medicare benefits. In addition, Petitioner has failed to demonstrate that the court of appeals has improperly applied well settled federal law concerning the review and payment of Medicare claims in this matter. Instead, Petitioner has concocted a novel tolling theory without any legal basis in an attempt to prevent the expiration of his claims that relies on the Medicare appeals process. In any event, Petitioner's concession that he has prevailed on the administrative review of his claims renders these issues moot as no further review is available to him.

Respondent respectfully requests that the Court deny the Petition for Writ of Certiorari and affirm the opinion of the court of appeals.

Respectfully submitted,

JOHN B. SCOTT
Counsel of Record
ANDREW W. YUNG
DENNIS J. KEITHLY
SCOTT YUNG LLP
208 N. Market Street, Suite 200
Dallas, Texas 75202
Phone: (214) 220-0422
Facsimile: (214) 220-9932

Attorneys for Respondent